A report to the Legislature

Supplemental Security Income (SSI) Managed Care Expansion

Chapter 518, Laws of 2005, Section 209(20)

October 2005

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TABLE OF CONTENTS

Enabling Legislation: Chapter 518, Laws of 2005, Section 209(20)

By October 1, 2005, the department shall report to the appropriate committees of the legislature on the potential fiscal and programmatic costs and benefits associated with an expansion of managed care pilot programs to SSI and other eligible Medicaid elderly and disabled persons.

EXECUTIVE SUMMARY

RECOMMENDATION: There is growing evidence that providing managed care for Supplemental Security Income recipients can create savings over the long run, in part because these recipients are the state's most costly group to cover.

- This report recommends that SSI clients be enrolled in managed care in order to:
    - Increase access to care
    - Provide a medical home
    - Improve the quality of care
    - Better predict medical expenditures
    - Increase state savings opportunities.
- This report also describes the potential fiscal and programmatic costs and benefits associated with an expansion of managed care pilot programs to SSI beneficiaries, and the report suggests further analysis needed to more accurately define these factors.

THE POPULATION: SSI recipients are low-income but may share few characteristics.

- They can be children or adults with chronic and severe disabilities, or they may be elderly persons who qualify for low Social Security benefits or none at all.
- Collectively, they represent perhaps the most vulnerable group of people receiving health-care assistance from the state of Washington.
- In Washington State, 108,977 persons – 14,179 aged and 94,798 disabled and blind – received SSI payments in December 2003.
- The disabled (non elderly) SSI beneficiaries include special needs children, developmentally disabled, the severely and persistently mentally ill, physically disabled young adults, individuals with HIV/AIDS, as well as individuals who are blind, have traumatic brain injuries, or whose medical conditions have been exacerbated by substance abuse.

PROGRAMMATIC IMPACTS:

- Managed care can increase access to health care, with better coordination of care and bring a greater emphasis on preventive care.
- Costs become more predictable and the managed-care environment allows for greater cost effectiveness.
- Patients and providers also face a learning curve, and the transition would include a potential disruption of continuity of care for some SSI recipients.
- The state has a number of options to choose between in implementing managed care for this population.

FISCAL IMPACTS:

- The data suggests there is a ramp-up phenomenon in which the health plans, enrollees, and provider community become increasingly accustomed to the managed care setting over time.
- Fiscal savings in other states range from 3 percent to 9 percent in initial years (when comparing the cost of managed care to fee-for-service).
- Later years show increased savings of 10 percent to 19 percent.
- Savings are attributed to the managed care organization's ability to both control costs (such as prescription drugs) and to use preventive care and disease management techniques that reduce preventable hospitalizations.
- Further analysis is needed to determine how these savings opportunities might extend to a Washington State model.

BACKGROUND

❖ SSI eligibility

Supplemental Security Income (SSI) is a federal cash assistance program for individuals who are 65 or older, blind, or disabled. These individuals also qualify for Medicaid coverage. The SSI program works as a safety net for individuals who have little or no Social Security or other income and limited resources.

To meet the disability criteria, an adult must have a physical or mental problem that keeps him or her from performing substantial work. An eligible child must have a disability that results in marked and severe functional limitations. For both groups, the disability must be expected to last at least a year or result in death.

❖ SSI caseload size

In Washington State, 108,977 persons – 14,179 aged and 94,798 disabled and blind – received SSI payments in December 2003 (Social Security Administration's most recent figures).

Of the 108,977 SSI recipients in Washington State:

- 24,923 were aged 65 or older;
- 70,957 were aged 18 to 64; and,
- 13,097 were under 18.[1]

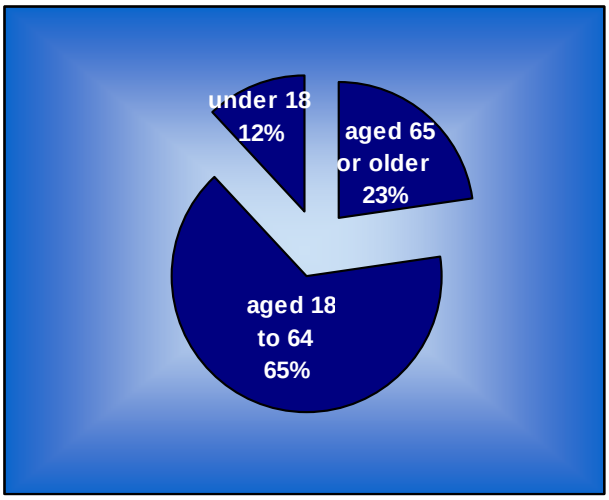

Figure 1

❖ SSI caseload characteristics

According to an article in Health Affairs[2] magazine, the disabled (non-elderly) SSI beneficiaries are very heterogeneous and include at least four distinct groups: special needs children, developmentally disabled children and adults, the severely and persistently mentally ill, and physically disabled young adults. The population also includes many individuals with HIV/AIDS as well as people who are blind, who have traumatic brain injuries, or whose medical conditions are exacerbated by substance abuse.

The Health Affairs article points out that these subgroups "…have their own advocates, agendas, and relationships with both elected and executive branch officials…and have also had separate government agencies with which to work." Each group requires costly and specialized types of medical care – and each may have specific needs that are different from those of many other elderly recipients. Further, "Medicaid spends more on the non-elderly disabled than on any other group," including higher costs for long-term care.[3] The growth of disabled eligibles has been particularly noteworthy.

❖ **Washington's current costs**

Table 1 outlines SSI CY2006 forecast average per capita expenditures by Category of Service[4]

TABLE 1

	Inpatient	Outpatient	Physician	Drugs	Lab	Home Health	Optical	DME	Other	TOTAL
Aged	$46.28	$24.23	$19.40	$41.80	$1.11	$1.46	$2.27	$50.94	$15.86	$203.35
Blind/Disabled	182.72	67.28	59.26	202.71	2.96	10.44	2.47	30.45	26.52	584.81

NOTE: The per person cost to the Department of Social and Health Services (DSHS) for the aged population is much lower than the blind and disabled, due to the high prevalence of other insurance, including Medicare.

OTHER STATES' EXPERIENCE

According to *Medicaid Managed Care Cost Savings-- A Synthesis of Fourteen Studies,* a July 2004 Lewin Group report[5] prepared for America's Health Insurance Plans, about 39 percent of Medicaid recipients nationwide are enrolled in managed care – but 88 percent of the Medicaid expenditures are paid via fee-for-service (FFS). The Lewin Group attributes the high FFS expenditures to the fact that most states do not offer managed care to disabled Medicaid recipients. These recipients, which comprise a relatively small percentage of Medicaid recipients, represent the highest-need, highest-cost categories and use a disproportionate share of Medicaid resources.

A number of states have been enrolling SSI clients in managed care in recent years. It is dangerous to compare states' managed care programs because there are wide differences in the programs. However, a number of states have demonstrated savings for their managed care populations in certain circumstances.

The Lewin Group report states: "The studies present compelling evidence that Medicaid managed care programs can yield savings." Further, the report says, "The studies provide some evidence that Medicaid managed care savings could be significant for the Supplemental Security Income (SSI) and SSI-related population."

Some of the categories with the largest savings identified in the report:

- **SSI/SSI-Related Population**: There is some evidence that savings could be significant for this population because these recipients typically are high users of services and the most costly group for states to cover. This group accounted for 60 percent of managed care savings in Arizona. In Kentucky, SSI recipients made up only 25 percent to 34 percent of total enrollment but accounted for 53 percent to 61 percent of the savings. Note: These savings were in programs where all SSI clients were mandated to be enrolled into managed care.

- **Inpatient Hospital Length of Stay**: The savings are largely attributed to reductions in inpatient hospitalizations. Inpatient hospitalizations, however, are historically much lower in Washington State than other states so this finding may not hold true for Washington. Certified public expenditures (CPE) for Critical Access Hospitals do not impact savings, since these enhanced rates would be built into the rates for managed care.

- **Preventable Hospitalizations**: The SSI population enrolled in California's Medi-Cal managed care program experienced a decrease of 25 percent in the rate of preventable hospitalizations as compared to a 38 percent reduction for the Temporary Aid to Needy Families (TANF) population. Texas' STAR+PLUS program reduced inpatient stays by 28 percent. Again, these are mandatory-enrollment programs for SSI recipients.

- **Prescriptions**: Pharmacy is another area of savings for states. However, Washington already receives prescription drug rebates, so this area may also have limited savings potential. However, there may be potential to offset the state's rebates purchasing advantage with the use of lower-cost drugs (generics) and fewer prescriptions due to better management of the pharmacy benefit.

Summary: Although savings have been attained in some states, Washington State would need to review these programs carefully before concluding that specific savings assumptions could automatically be extended to a Washington State model.

WASHINGTON'S PAST EXPERIENCE WITH SSI MANAGED CARE

The Medical Assistance Administration (MAA) first piloted managed care for SSI enrollees in 1997. Enrollment was mandatory, and the project started with Clark and other Eastern Washington counties. However, too few health plans were willing to renew contracts for 1998, primarily for fear of adverse risk and other rate-related issues, and the program ended in December 1997.

A Center of Health Care Strategies (CHCS) consultant was hired to evaluate the project. The report's findings included:

Use Risk Adjustment and Risk Sharing -- Rate setting, especially for a population with diverse and extensive health care needs, is complicated. The initial premium rate set for SSI enrollees was based on utilization under the fee-for-service (FFS) program. However, because access to care was enhanced under managed care, enrollees had a pent-up need for services and utilized services at a higher rate than for what the managed care premiums had been based upon. Risk-adjusted capitated rates are set according to the cost of clients being served by the plan, compared to other plans. Such rates are cost-neutral to the state and are used to avoid selection bias, so no plan is penalized by attracting a disproportionate share of high utilizers. For instance, one plan may be known for its HIV/AIDS specialists, so those clients would select that plan at a higher rate than other plans. CHCS recommended risk sharing, such as per-MCO risk corridors outside of which the state would share a portion of unanticipated gains and losses, and stop-loss provisions, which would cap an MCO's total loss for any individual enrollee. Stop-loss would not prevent a plan from losing money overall, but it would reduce problems with so-called "million-dollar babies" and other expensive individual outliers.

Enroll on a Voluntary Basis—Implementing managed care generates a level of anxiety amongst providers, clients, plans, advocates, and other stakeholders. Voluntary enrollment provides a safeguard for these complicated clients. It allows plans to become familiar with serving this population, and it avoids abrupt interruptions in continuity of care. The issue of determining financial impact in the plans would also be allayed with a voluntary or phased-in program.

Develop Linkages Outside the Traditional Medical Community—Because of the need for personal care assistance, social support, home modifications, etc. this population has, it is important to augment relationships with other service providers and community resources.

Thus, even though DSHS' previous SSI managed care experience did not continue, the recommendations from CHCS are encouraging that managed care does seem feasible if modified.

RATES CONSIDERATIONS

It was the opinion of CHCS that "Significant budget savings in the short term are not likely." The initial start-up costs and the time necessary to identify and achieve savings in medical care utilization mean that neither the state nor participating managed care organizations (MCOs) should anticipate significant short-term budget savings or profits.[6]

The much lower inpatient costs Washington experiences compared to other states reiterates this point. Rate setting has a number of other considerations as well.

Start-Up Costs: There are high start-up costs for plans to hire extra staff to provide case management, develop client materials, set up new systems, etc.

Ramp Up: The data suggests a ramp-up phenomenon exists as the health plans, enrollees, stakeholders, and provider community become increasingly accustomed to the managed care setting over time. Studies note there needs to be a realistic opportunity to achieve a favorable profit/operating margin, since there is a considerable financial risk to managed care organizations (MCO), which needs to be offset in order to attract participating plans. Attributes of the Medicaid population, such as transitory eligibility and literacy barriers, further challenge MCOs' ability to achieve savings.

Volume: A certain volume of clients is necessary to offset start-up costs and reduce the financial risk of clients whose medical expenditures far exceed the monthly per member, per month reimbursement.

Built-in Savings: Building in savings to the state must be weighed against the prospect of setting rates too low to attract MCOs. Typically, rates to MCOs are based upon the state's fee-for-service equivalents and must be actuarially-sound if serving Medicaid clients, per federal rules. Plans generally are able to achieve savings to offset start-up and administrative costs by instituting additional utilization reviews, case management, disease management, formularies, etc. But savings to the state usually occur in subsequent years after implementation, because the premium rates generally do not rise as steeply as the fee-for-service equivalents. "A high tolerance for deferred gratification with respect to cost savings is critical. Short-term savings are difficult to achieve due to high initial utilization (due to pent-up demand and improved care coordination), difficulty in setting appropriate capitation rates, and up-front administrative costs."[7]

Voluntary or Mandatory Enrollment: There are pros and cons to each type of enrollment.

On the plus side for mandatory programs:

- States that have achieved savings with managed care have primarily used a mandatory model. As noted, however, these states have different situations than Washington.
- The volume of clients is more predictable and larger than with voluntary programs.
- Managed care means fewer claims for DSHS to process.
- Managed care would bring increased access and care coordination.

- Health plans prefer mandatory enrollment, so this option can maximize plans' interest in participating.

On the other hand, mandatory enrollment can be problematic:

- Washington's 1997 mandatory program for SSI beneficiaries met with great resistance from the providers, clients and community stakeholders. To reactivate a similar mandatory model, particularly if statewide and with no phase-in would appear to be repeating the same unsuccessful path. Extensive education about the positive outcomes achieved in managed care would be necessary to overcome this anticipated resistance.
- This vulnerable population can be easily confused by managed care, which means the intense needs of this population and the providers serving them, such as skilled nursing facilities' residents and foster children, could be at risk. Special attention to the fragile network serving them and a gradual learning curve among providers and community would be needed, along with clearly written client materials, outreach programs and workers, etc.
- Continuity of care may be disrupted. Establishing an adequate provider network, whether through voluntary or mandatory enrollment, would be a priority. Specialty care would be required as part of any network, with the provision that clients be allowed to see an established specialist as their primary care provider. In some cases, clients would have to decide whether to stay with providers who sign up with different plans or who don't sign up at all.
- Many providers treat this population because of long-term established patient relationships. However, they often don't take other Medicaid clients, and managed care could persuade them to abandon these relationships, too.
- Access to specialty care is difficult, even for managed care plans. Mandating all clients to enroll into managed care, particularly without a phase-in period, may jeopardize the health of certain clients.

The benefits of voluntary enrollment include:

- Only those who believe they would benefit from managed care would enroll initially -- this should minimize the concerns of advocates and potential enrollees, and ease the initial outreach, education, and evaluation burden of MCOs. The department and plans are sensitive to linking clients to existing providers whenever possible, so this would be less of an issue over time. It is generally not an issue at all when Healthy Option clients already enrolled with a plan become eligible for SSI.
- The financial and health risks are lower for all parties. The existing fee-for-service system remains as a fall-back for beneficiaries, and MCOs, providers and the state can be reasonably confident the program won't grow rapidly and

unpredictably. The plans would feel more assured of valid rates and thus would be more willing to participate in managed care for this population.

- Voluntary enrollment would allow time to learn about the population and its unique characteristics and challenges prior to implementing a mandatory program.
- Voluntary enrollment allows for flexibility in phasing in managed care.

But there also are drawbacks to voluntary enrollment:

- The number of clients who may enroll in managed care under a voluntary model may be small. The administrative costs for a small number of clients can be a disincentive to plans to participate.
- Voluntary enrollment may result in disproportionate utilization among enrollees, with sicker clients choosing not to enroll in managed care. Low utilizers might be drawn to managed care because they are less concerned about accessing their particular providers. If higher-cost clients opt out of managed care, the rates could overcompensate the plans. On the other hand, if premiums based on a healthier population go significantly lower, plans may not wish to participate.
- Rate-setting is more complicated than with mandatory models, given the issue of "opt-outs."
- A "lock-in" feature where clients stay in the same plan for a certain time period allows plans to average out their expenditures over time. This would not be possible with a voluntary program.

Program Costs: These include such things as enrollment materials, programming system costs, staff training, forums to educate the community, translator costs for DSHS phone staff and actuary costs. The more complex the managed care model, the greater its program costs. Additional hiring is probably not anticipated unless the program is mandatory and/or dual Medicare/Medicaid eligibles are included.

In the first year, programming changes to the MMIS, monitoring, training, and contracted actuarial costs would increase. Calls to DSHS client and provider phone lines will be high during implementation but taper off after several months.

Note: Because transition to a new Medicaid Management Information System (MMIS) computer is under way, DSHS will be limited as to the number of programming changes it can make to the current system. Current programming will allow DSHS to add another line of managed care, but age/sex factors cannot be added to the rates. Given this transition, and with the new system not expected to go fully operational until the second half of 2007, technical requirements become a caveat the state must weigh carefully.

OPTIONS FOR A PROPOSED SSI MANAGED CARE MODEL

A number of factors come into play when designing a managed care model. However, if DSHS were to implement a managed care plan for the SSI population, the experience from Washington State's own past SSI managed care experience would logically drive many of the decisions in designing the model. Some of the important factors involved with designing any managed care model would include:

Managed Care Plans: Any licensed health carrier with adequate capacity to provide services should be allowed to participate in providing managed care to SSI beneficiaries. Currently, there are six insurance plans serving Healthy Options enrollees. It is anticipated that a number of these plans will be interested in serving the SSI enrollees, as well as some new contractors. Plans would undergo an evaluation of provider network adequacy, as well as internal system capacity, to enroll complex clients.

Benefit Coverage: Which medical benefits are covered by the plan for SSI enrollees can influence the model. The easiest option would be to cover the same benefits as for Healthy Options beneficiaries. These benefits include such things as physician and hospital services, physical, speech, and occupational therapies, prescription drugs, transplants, laboratory and medical imaging services, care coordination, and some outpatient mental health. Other services not covered under the managed care contract, such as long-term care, normally provided to SSI clients would be covered by the department. Under this scenario, the same contract can be simply amended for the SSI line of business. Eventually, the benefit package might be expanded to include these other services as well, after the Washington Medicaid Integration Partnership (WMIP) program has been fully implemented and evaluated. WMIP's SSI managed care design includes mental health, substance abuse, and long-term care services.

Safeguards: The federal balanced budget act (BBA) of 1997 requires certain safeguards for special health care needs enrollees in managed care. These include the option to use a specialist as a primary care provider (PCP) or to have direct access to a provider, the assessment of the individual and development of a treatment plan, and for SSI children, the option to disenroll. MAA will consider require plans to consider SSI enrollees to be clients with special health care needs. In addition, plans must demonstrate adequate networks of specialists, provide access within specified timeframes, have quality improvement plans and receive a site visit *and* an external review annually to review operations, and grievance processes. MAA also maintains a hotline for client complaints and problems.

Service Areas: Several options exist: The state could choose two pilot areas for implementation and the plans could decide whether or not to add SSI clients in those counties. Alternatively, the state could conduct an request for proposals (RFP) or request for Information (RFI) and select counties based on network adequacy, choice of plans, etc. Or, enrollment could be allowed statewide, with a phased-in approach or all at once. It is likely that plans would only provide services to enrollees where they currently have Healthy Options line of business. Enrollment could begin phased in key areas first or go statewide all at once. Snohomish County would need to be excluded initially because of the current WMIP already operating for SSI beneficiaries.

Provider and Community Involvement: Health plans educate their providers about the SSI line of business and the department sends numbered memos to providers to announce new managed care programs, but any change requires sensitivity to the impact of managed care. Educational forums need to be held for key stakeholders in communities, such as mental health providers, child-serving organizations, health departments, and others serving the disabled population.

Federal Waiver/State Plan Amendment: A state waiver or state plan amendment will be necessary to implement SSI. If the program is not implemented statewide, this relatively easy waiver would be requested from the Centers of Medicare and Medicaid Services (CMS). If the program is mandatory, the waiver process will be more rigorously scrutinized by the federal government. Amongst other requirements is an independent evaluation of cost-effectiveness, quality of care, and client satisfaction.

Dual Enrollees Inclusion: Clients who have both Medicare and Medicaid coverage present complex coordination of benefits issues the DSHS is currently studying, particularly in relation to managed care. Inclusion of dual enrollees would impact rate setting, pharmacy benefits, integration with Medicare-Advantage Special Needs Plans, and other complications. It is recommended dual enrollees be excluded at this time.

Voluntary or Mandatory Enrollment: Whether to voluntarily or mandatorily enroll clients is a critical decision and makes a large difference on ease of implementation, rates, administrative burdens, etc. Table 2 outlines five general options to enrollment, with pros and cons to each:

TABLE 2

OPTION	PROS	CONS
A. As Healthy Options (HO) clients become eligible for SSI, they remain enrolled with their managed care (MC) plan, with a higher SSI premium rate beginning the next month. Clients have the option to opt out, or switch plans.	• Maintains continuity of care for new SSI clients already in mc • No pent up demand • Less ramp up necessary • All plans can participate, if desired • Provides plans experience handling SSI clients with minimal disruption • Easy to program system changes • Easy to administer • Option out alleviates client, provider & stakeholder fears; less community outreach and education necessary • Little provider education needed • If not statewide, waiver would be easier to obtain • Increased access to care & care coordination than under fee-for-service (FFS)	• Volume of clients may be too small to make adequate determination of cost-effectiveness • Administrative costs may be high in comparison to volume of clients • Rate-setting will be complicated and need to be to be adjusted to account for high utilizers, if they opt out of MC • System demands extensive & may cause delay in implementation, depending on the new MMIS capabilities • Plans would need to contract with more specialists • Plans may need to develop emergency procedures for specialists who act as PCPs
B. Offer SSI clients the option to enroll voluntarily (statewide)—this option would also include option A	• Less ramp up necessary • All interested plans can participate • Gives plans experience handling SSI clients with minimal disruption • Minimizes disruption to continuity of care • Easy to program system changes • Easier to administer • Option out alleviates client, provider & stakeholder fears • If not statewide, waiver would be easier to obtain • Increased access to care & care coordination than under FFS	• Volume of clients may be too small to make adequate determination of cost-effectiveness • Administrative costs may be high in comparison to volume of clients • Premiums will need to be to be adjusted if high utilizers opt out of MC • Rate-setting complicated • Difficult to price pent up demand • Plans would need to contract with more specialists • Plans may need to develop emergency procedures for specialists who act as PCPs

C. Conduct an RFP for mandatory SSI in limited counties	• Can review specialist networks and award to plans where capacity • Volume of clients will be higher and will reduce risk to plans • Administrative costs more in line with number of enrolled clients • Rate methodology simpler than with voluntary • All interested plans can participate • Increased access to care & care coordination than under FFS • Health plans prefer mandatory enrollment • Provides best data for decision-making	• Extensive outreach work necessary to overcome clients, providers, and stakeholders fear of mc. Additional time & extra staff may be necessary for both plans & HRSA • Pent up demand will be difficult for rate-setting and is costly • MMIS capabilities • Waiver for state-wideness mandate may be difficult to obtain • Disruption to non-MC providers • Increased phone calls from clients, providers, stakeholders • Plans would need to contract with more specialists • Plans may need to develop emergency procedures for specialists who act as PCPs
D. Mandate enrollment in only two counties, one urban and one rural	• Volume of clients will be higher and will reduce risk to plans • Administrative costs more in line with number of enrolled clients • Rate methodology simpler than with voluntary • Increased access to care & care coordination than under FFS • Health plans prefer mandatory enrollment	• Extensive outreach work necessary to overcome clients, providers, and stakeholders fear of MC. Additional time to implement & extra staff may be necessary for both plans & HRSA • Pent up demand will be difficult for rate-setting and is costly • Not all interested plans would be able to participate or as fully as desired • Change to state plan may be difficult to obtain • Disruption to non-MC providers • Increase in complaint calls & exemption requests expected from clients, providers, stakeholders.

		• Plans would need to contract with more specialists • Plans may need to develop emergency procedures for specialists who act as PCPs
E. Mandate enrollment statewide	• Volume of clients will be higher and will reduce risk to plans • Administrative costs more in line with number of enrolled clients • Rate methodology simpler than voluntary • Volume of FFS claims reduced, as in other options, but to a larger magnitude • Increased access to care & care coordination than under FFS • Health plans prefer mandatory enrollment	• Extensive outreach work necessary to overcome clients, providers, and stakeholders fear of mc. Additional time to implement & extra staff will be necessary for both plans & HRSA • Pent up demand will be difficult for rate-setting and is costly • Waiver may be expensive because of evaluation, difficult to obtain & could delay implementation • Disruption to non-MC providers • Increase in complaint calls & exemption requests expected from clients, providers, stakeholders. • Areas in the state have contracting difficulties with specialists

RECOMMENDATIONS

It is difficult to project that Washington State would achieve the savings other states have experienced from their managed care programs because of differences in programs and utilization controls already in place in Washington State. However, it seems likely that better access and more appropriate care can be achieved with managed care for the SSI beneficiaries. After start up, it is anticipated that some savings will be achieved, depending on how the rates are constructed.

- SSI clients should be enrolled in managed care in order to increase recipients' access to necessary care, to provide a medical home, to improve the quality of the care received, in order to better predict medical expenditures and to reduce the expenditures growth trend.

- Savings expectations should be phased in. Start-up costs need to be accounted for, even if a mandatory program is implemented, so no savings should be projected for the first year. Plans also have a real fear that a pent-up demand for care could escalate initial costs. Discounting rates the first year would discourage some plans from participating.

- Cost-effectiveness of managed care should be studied in an existing program and then adapted to the SSI line of business.

NOTES

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[1] Source: "*Washington State Statistics, December 2003*", Social Security Administration, SSI administrative files

[2] "*Where the Action Really Is: Medicaid and the Disabled*", Bruce C. Vladeck, HEALTH AFFAIRS – VOLUME 22, Number 1 (January/February 2003)

[3] Centers for Medicare and Medicaid Services, *A Profile of Medicaid: Chartbook 2000* (Washington: US Government Printing Office, 2000), 22, 65-66

[4] MAA Rates, Division of Business and Finance

[5] *Medicaid Managed Care Cost Savings—A Synthesis of Fourteen Studies,* The Lewin Group (July 2004)

[6] James M. Verdier, "*Washington State's Experience in Extending Medicaid Managed Care to the SSI Population: A Retrospective Analysis,"* Center for Health Care Strategies, Inc. Princeton, NJ. August 1998, p. 17

[7] *Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States,* Center for Health Care Strategies (September 2003)